Mental Health

News

Winter 2008

Capsticks

Absconding - New neglect test

Savage

Supervision or care order?

LOA Claim

Learning Disabilities Audit

HSE prosecution

Right to life - neglect test

Savage v South Essex Partnership NHS Foundation Trust C/A 20.12.07

In a case that will be much quoted at Inquests and compensation claims, the Court of Appeal in December overturned the High Court that had said that there could be no breach of Article 2, unless the negligence was gross and "sufficient to sustain the charge of manslaughter".

Now, it will be much easier to establish neglect - making it more important for Hospitals to ensure their patients come to no harm.

She had suffered from paranoid schizophrenia and was detained under s.3 in an open acute psychiatric ward. After a number of attempts to leave, she absconded and jumped in front of a train and was killed.

The family brought proceedings for compensation based on a breach of Article 2. Surprisingly, no claims were made in common law negligence or otherwise. The allegations of negligence were that the hospital failed to take sensible and sufficient safeguards, given her known risk of both absconding and suicide. It was agreed that any negligence did not amount to 'gross' for which there could be a manslaughter charge.

The issue was the exact test that should be applied to Article 2 (that is concerned with a right to life). The High Court Judge said that in order to establish that, a family would have to prove that the Trust had been guilty of "…at the least, gross negligence such as would be sufficient to sustain a charge of manslaughter". The claim was dismissed.

The European Court in Osman v UK 1998 said that there was a breach of the European Convention of Human Rights, if the Applicant could "…show that the authorities did not do all that could reasonably be expected of them to avoid a real and immediate risk to life of which they have, or ought to have, knowledge".

The Court considered a number of cases, especially the ECHR case of *Tarariyeva v Russia 2006*, which concerned a prisoner who required significant treatment in a general hospital, but on return to a prison hospital received negligent care (as he did not have anything like sufficient treatment to deal with a massive blood loss).

The Court of Appeal held that this case demonstrated that a detained patient "…was in no different position from a person detained in the prison hospital or a civilian hospital while a prisoner". They then said "….both prisoners and detained patients are under the control of the state in a way in which ordinary patients are not".

They continued - "We have reached the conclusion that there is no reason to afford those detained under the MHA, any less rights under Article 2, than those detained in prison or prison hospital, whether closed or open…In order to establish a breach of Article 2, the Appellant must show that at the material time, the Trust knew, or ought to have known, of the existence of a real and immediate risk to the life of S from self-harm and that it failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk".

In other words, the threshold is significantly lower than "the test for gross negligence".

Readers will readily appreciate that this case is highly significant in both compensation claims and perhaps, especially, Inquests.

It will certainly be argued at future Inquests that a verdict of neglect really depends on the test of foreseeability, which in turn is a significantly lower threshold and therefore much easier to establish. This will therefore lead to more requests from families for a neglect verdict at Inquests and this in turn is likely to lead to an increase in negligence claims, thereafter. It will also lead to longer Inquests whilst negligence issues are argued out, and with witnesses being cross-examined about foreseeability.

Also, in view of the House of Lords in Middleton, it will be argued that there needs to be a full Article 2 Inquest Inquiry. There is even the prospect that harm was foreseeable and where the relatively straight forward measures may minimise the risk. Readers may appreciate that an Article 2 Inquest involves a great deal more scrutiny of policies and procedures and how they operate to keep patients safe, than in other cases. Neglect can also involve system neglect and, given the much lower threshold that has to be passed in order to establish it (following on this Court of Appeal Judgment), it is certain that it will attract much more argument and become much more contentious than when the High Court gave its Judgment earlier.

Capsticks has a number of advocates regularly attending Inquests, including Philip Hatherall, Rob Wilson and Ashley Irons to whom any questions on these issues can be discussed.

Ashley Irons
Partner
Clinical Law

020 8780 4891
airons@capsticks.co.uk

Inquest refusal

Bicknell v HM Coroner, Birmingham 2007

B successfully challenged a Coroner's refusal to hold an Inquest, concerning her father who had significant mental health problems and died soon after admission to a nursing home.

Capsticks Inquest team often succesfully argue that facts do not require an Inquest, thus saving staff time and legal expense.

B had obtained an expert report which was very critical on 3 fronts. The medical records were extremely poor, there were concerns about high dose medication and, finally, the restrictive effect of a bucket chair.

The Court, in ordering an Inquest said, that an expert had raised issues that needed to be examined. Particularly about excessive medication, failure to give adequate antibiotic treatment and the restrictive effect of the chair. Potentially, there was an unnatural death and certainly sufficient for a proper Inquiry, i.e. an Inquest, to take place.

Philip Hatherall
Partner
Clinical Law

020 8780 4752
phatherall@capsticks.co.uk

Supervision or care order?

Local Authority X v M, F & E 2007

F suffered from schizophrenia, which had been untreated and he, together with the mother of 3 children, sought Supervision Orders. In contrast, the LA, supported by the children's Guardian, sought Care Orders in respect of the children.

Concurrent with these proceedings, F had been detained under the MHA but it was expected that he would shortly be discharged. His intention was to return to the family home where he had subjected his children to inappropriate and disinhibited sexualised behaviour, to include exposing himself and acting bizarrely.

The Court found a decision hard to reach but, on balance, because F would be managed by a Mental Health Community Team, felt that supervision would suffice. This was even though M was unlikely to appreciate or report concerns at an early stage if there was a repetition of previous behaviour by F. The Court accepted that generally in this situation there would be a shared parental responsibility between the LA and the parents, but felt that if there was insufficient cooperation in the future which would demonstrate that the Supervision Order was insufficient protection, the "ultimate sanction would be removal of the children".

Lindsay Gee and Ashley Irons are often asked by clients to advise upon children/mental health patients' issues.

Lindsay Gee
Partner
Clinical Law

020 8780 4706
lgee@capsticks.co.uk

LOA Claim

G v Central & NW London MHT 2007

A consultant psychiatrist was criticised for granting unescorted leave when her patient suffered significant injury as a result. G sought damages, for what was alleged to be negligent care by a Mental Health Unit to which she had been admitted, after making suicidal threats. She had, when on leave, put herself in front of a train and suffered injuries that she claimed had lasting physical and psychological effects upon her.

The Court rejected her negligence claim. Clients will be aware how difficult LOA decisions are.

She had been diagnosed with a depressive illness and was also treated for anxiety, agitation and disturbed sleep. Although she had been detained under the MHA from time to time, she was usually informal. After 4 weeks the doctor granted unescorted leave around the hospital grounds and then for short periods at weekends.

G had earlier run away, despite having made it known that she was thinking of "…doing something stupid". Following her return, she was still allowed to go home on 2 further occasions.

2 weeks later, when unescorted, she stepped in front of a train and suffered injuries as a result. Her own expert said that giving unescorted LOA within the grounds was negligent, because there was a risk of self-harm that was "obvious". Secondly, it was negligent requiring G to take responsibility for her own actions.

In contrast, the Trust's expert said that she would have taken exactly the same measures as the doctor. Even after the absconsion, she would still have granted subsequent LOA (as happened here).

In a very sympathetic Judgment, the Court accepted that the patient's presentation was mixed and that they were doing their best to manage her "…very difficult behaviour". G clearly wanted more freedom and visible signs of progress towards rehabilitation. Indeed, it seemed that she had benefited from the leaves that she had had. Aiming to make G take more responsibility for her own actions was a reasonable treatment plan and that granting unescorted leave, was neither illogical nor unreasonable. Furthermore, G's claim did not take into account potential consequences if leave had been denied, as well as the benefits of leave.

Even if there had been an over-emphasis on G taking responsibility for her own actions, or even if her care by any member of staff might be criticised, it did not get near to negligence.

The doctor was justified in taking into account all the matters that she did. The decisions she made were those that another reasonable consultant psychiatrist who, if faced with the same issues, may well have also made.

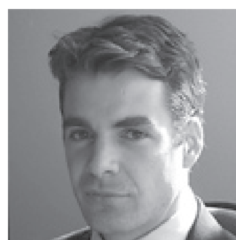
Although the report of this case does not give much detail, the critical feature, when making decisions such as this is how they are recorded. Judges understand perfectly well that making a decision that involves risk is part and parcel of what a consultant psychiatrist does. What they expect to see is a consultant considering the potential benefits and disadvantages and weighing them up before reaching a decision. In other words, striking a fair balance between benefits and risks, having regard to the overriding duty of care that clinicians have.

In this case, the consultant had a treatment plan that would have been followed by many. There were risks inherent in it and provided a consultant, in these circumstances, writes sufficient in the clinical notes to demonstrate the upside and the downside (and in particular an awareness of risk), Judges will be slow to interfere. After all, the role of Judges, as they have said increasingly in compulsory treatment cases (refer to previous Newsletters), have a review function. In other words, they do not hear the evidence and consider what clinical decision they might have made in the particular circumstances. What they are looking for is evidence that the doctor has taken into account the essential considerations for and against a particular course of action.

Where Judges lose sympathy, is where there is no evidence of any consideration at all and a doctor is having to explain in a subsequent statement, firstly why their notes were either non-existent or inadequate and, secondly, what their considerations at the time were.

There are numerous cases that have sprung out of Coroner's Courts, with a similar theme – for further information upon how an organisation and individual clinicians can protect themselves against subsequent proceedings, please speak to Ashley Irons, Philip Hatherall or Robert Wilson. Francis Lyons defends claims for the NHSLA arising from clinical decisions in these circumstances.

If you would like a seminar on these risk issues contact Fancis Lyons on 020 8780 4891 or flyons@capsticks.co.uk



Francis Lyons
Solicitor
Clinical Law

020 8780 4891
flyons@capsticks.co.uk

Learning Disabilities Audit

In December 2007, the Healthcare Commission published their first audit of learning disability services in the country, entitled "A Life Like No Other". PCT's and Providers will be assessed against its requirements.

This audit covered 72 NHS Trusts and 17 independent organisations providing 638 individual services. In all, it recommended over 2,500 steps to be taken, and said that from now on there will be spot checks. These inspections will also include organisations which were not audited when compiling this report.

Clients providing learning disability services will note that there will be annual performance ratings in the future. Policies, compliance with indicators, and training will all be monitored now.

Capsticks are often consulted when the Healthcare Commission have inspected and produced their draft report for factual comment – as well as after the report is finalised. Capsticks lawyers attend meetings with clients, with the Healthcare Commission Inspectors, for example, where it is said that a standard is "…not met" when it is, or largely so.

In general terms, they found that "….most services appeared to be providing basic standards of care and had, on the whole, committed teams of staff. There were unacceptably wide variations in the standards of care between services, both within an organisation and when compared to others. In most organisations, we have concerns about the quality of care overall".

They particularly highlighted the procedures for the safeguarding of vulnerable adults, poor planning of care and training and the lack of internal and external scrutiny. They criticised the absence of stimulating activities and opportunities and, generally speaking, a lack of leadership.

The Healthcare Commission stated that they will introduce a set of performance indicators "…as part of our 2008/2009 Annual Health Check…they will be announced in 2008, but will include measures, important in assessing quality of care".

This includes assessing the quality of commissioning. They are expecting PCTs "…to play a more active role in commissioning learning disability services" and who "…must take into account recently published DoH Guidance on commissioning specialist health services for adults with learning disabilities". (DoH 2007 Commissioning Specialist Adult Learning Disability Health Services – Good Practice Guidance).

They expect Commissioners to "…review this report and consider how best to meet the challenges raised. They must explicitly consider this commitment as part of local area agreements, to be published by the end of June 2008".

Provider organisations are expected to "…evaluate and review their care and learn from these findings".

Capsticks have considerable experience drafting all the required documentation on behalf of PCT Commissioners. In addition to SHAs and PCTs, Capsticks also represent the providers of services. This report, for those concerned with learning disabilities, will have an immediate impact. For further information and advice please contact James Reynolds, David Firth, Ashley Irons or Lindsay Gee.

Ashley Irons
Partner
Clinical Law

020 8780 4891
airons@capsticks.co.uk

Open window liability - HSE Prosecution

In January, the Avon & Wiltshire Mental Health Partnership NHS Trust admitted a breach of the Health & Safety at Work Act following a prosecution by the HSE.

A 77 year old female patient fell 5.5 metres from an open window at one of the Trust's Hospitals. Unfortunately, for all concerned, the Trust had identified that the window restrictors, provided to prevent falls, did not meet the reasonable standard - but the problem had not been rectified. As a result, Sunderland Magistrates Ordered the Trust to pay a fine of £20,000 and prosecution costs of £12,500.

Based on our experience of such claims it is likely that the patient concerned is already consulting solicitors for a claim in negligence as well, which will easily eclipse the amount Ordered by the Magistrates Court.

Remarkably, the HSE's Health & Social Care Services Unit identified at least 7 fatal accidents and approximately 30 major injury incidents attributed to falls from windows, during the 2 year period 2002/2003 to 2004/2005.

The patient only suffered a fractured vertebrae and a broken ankle. Other similar claims which Capsticks have dealt with have seen patients suffer from brain injuries, an exacerbation of pre-existing mental disorders, as well as amputated limbs.

However, these types of cases clearly show that the adage of a "stitch-in-time saves 9" is apt.

The important point to note is that if internal risk assessment teams (or the external HSE) identify a fault, it is imperative that hospitals get on and correct it as soon as possible.

The same H&S issues arise at Inquests where it may be said that there has been a breach of Article 2, Right to Life. Capsticks' Ashley Irons had a recent Inquest where one of the issues was whether a bedroom door handle should have been changed, as that was the ligature point from which a patient hung himself. In that case, the hospital audit of all wards had identified door handles as a risk and were to be replaced. The process of replacement was underway, but had not reached the ward in question. One of the arguments raised at the Inquest was that the hospital should have taken remedial action upon all door handles as a matter of urgency. The Coroner agreed that there was a reasonable system of inspection in place, that works were underway and that in any event, the patient was subject to very frequent observations.

When taking part in a tender process, compliance with H&S Standards and Audits, will certainly be a factor taken into account when, for example, a PCT is considering out-sourcing services.

If you have similar issues or expect an HSE inspection, please contact Francis Lyons, Ashley Irons or David Firth.

David Firth
Partner
Dispute Resolution

020 8780 4738
dfirth@capsticks.co.uk

Capsticks Diploma in Clinical Risk and Claims Management 2008/09

The Capsticks Diploma in Clinical Risk and Claims Management is widely regarded as the definitive qualification for clinical risk managers and claims managers in the healthcare setting.

Venue: 77/83 Upper Richmond Road, London SW15 2TT, adjacent to East Putney underground station

Risk management module

1) Why accidents happen

2) Standards and risks

3) Risks in maternity care

Claims management module

4) Clinical negligence

5) The litigation process

6) Medico-legal emergencies and consent

For further information contact Catherine Macartney on 020 8780 4759 or visit www.capsticks.com/seminars

Mental Health Seminars

For further information contact Catherine Macartney on 020 8780 4759 or visit www.capsticks.com/seminars

Medico-legal emergencies and consent

(Wednesday 12th March 2008)
Capsticks' Diploma in Clinical Risk and Claims Management

A day focusing on the often high profile medico-legal emergencies in which important decisions need to be taken very quickly. The day also gives an introduction to the law of consent.

- Refusal of treatment
- Withholding and withdrawing treatment
- Child protection
- Inquiries

Prison Inquests: A Guide for healthcare providers

Wednesday 5th March 2008,
registration 3.45 pm, 4 - 6 pm seminar

This seminar will include:

- An introduction to inquests and the new wider ranging regime.
- An explanation of the key issues in prison inquests including problems and pitfalls for the PCT and how to overcome them.
- Potential liabilities for the PCT in negligence and corporate manslaughter.
- An interactive case study.

Certificate in Mental Health Law 2008

1) Sources of mental health law

(Wednesday 9th April 2008)

- Introduction to the legal system and effect of common law
- Mental Health Act 1983
- The Code of Practice & NICE guidance
- Impact of Human Rights & European Convention principles on UK mental health law

2) Capacity, consent and compulsory treatment

(Wednesday 21st May 2008)

- Capacity and compulsory treatment
- Advance decisions
- Treatment of informal/Bournewood patients
- Mental Capacity Act and living wills
- Issues in restraint and seclusion
- MHA Code of Practice

3) Detention, MHRTs and Managers' Hearings

(Wednesday 9th July 2008)

- Compulsory admission and discharge
- When are informal patients "detained"?
- Handling demands for witnesses and challenges to evidence
- Human Rights Act and European Convention implications
- MHRT and Managers' Hearings
- Managing witnesses

4) Reputation and Risk

(Wednesday 10th September 2008)

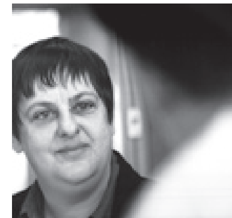
- Duties of care - interpretation and liability
- MAPPA
- Healthcare Commission inspection and standards
- Inquests
- SUIs and the consequences of management failure

5) Confidentiality and other legal issues

(Wednesday 29th October 2008)

- Regulatory framework
- Breaches of confidentiality and "not for disclosure" documents
- PLD including MCA v MHA
- Mental Health law update 2007

Capsticks' Mental Health Lawyers



Lindsay Gee
Partner
Clinical Law

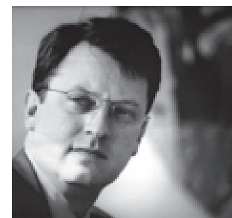
020 8780 4706
lgee@capsticks.co.uk

Ashley Irons
Partner
Clinical Law

020 8780 4891
airons@capsticks.co.uk

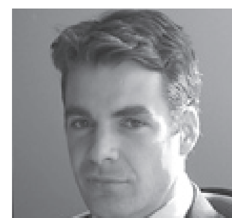
David Mason
Partner
Clinical Law

020 8780 4702
dmason@capsticks.co.uk



Peter Marquand
Partner
Clinical Law

020 8780 4706
pmarquand@capsticks.co.uk



Francis Lyons
Solicitor
Clinical Law

020 8780 4891
flyons@capsticks.co.uk

Capsticks Solicitors
77/83 Upper Richmond Road
London SW15 2TT

T +44 (0)20 870 2211
F +44 (0)20 8780 1141
DX 59461 - Putney
E info@capsticks.co.uk
W capsticks.com